BOSTON UNIVERSITY

SCHOOL OF SOCIAL WORK

A STUDY OF THE ADJUSTMENTS OF TWENTY PATIENTS FROM THE BOSTON STATE HOSPITAL WHO WERE PLACED IN JOBS AND HOMES IN THE COMMUNITY BY SOCIAL SERVICE

A Thesis

Submitted by

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(A.B., Radcliffe College, 1944)

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CHAPTER I

INTRODUCTION

PURPOSE

This is a follow-up study of the adjustments made by twenty patients from the Boston State Hospital who were referred to the social service department by the staff psychiatrists for placement in jobs and homes in the community at the time of their release on trial visit. The study was undertaken to determine what social factors were important in influencing the patient's satisfactory or unsatisfactory adjustments in the community, and what was the nature of the case work services given to these patients by members of the social service department during the year's period of supervision.

SCOPE

The material for this study was taken from the records of the Boston State Hospital in Dorchester, Massachusetts. These records were for the most part brief and incomplete, and the material was therefore supplemented by data from records of other agencies with whom the patient had had contact, by personal interviews with the workers active on the cases whenever possible, and in two cases by follow-up visits to the patients in the community.

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This study covers a period of eighteen months from March 1, 1946 to September 1, 1947. This period was selected as it was recent and at the same time included only those patients who had been living in the community for six months or more, as less than six months was not considered a fair trial period.

The twenty patients studied were selected at random from a group of forty-two. These forty-two patients were placed by social service during the stated period and received close follow-up supervision. The writer selected the first ten successful cases and the first ten unsuccessful cases from the group. An even number was selected from the successfully adjusted and the unsuccessfully adjusted groups in order that comparisons could be made of the more fixed factors (education, intelligence, marital status, and mental illness in the family), to determine what influence these factors had on the adjustments of the patients.

A schedule was prepared which the writer believed would produce the necessary information to answer the proposed questions. The cases were applied to the schedules and the material abstracted from each of the twenty cases. Information gained from other agencies or through personal interviews with workers and patients was incorporated as part of the background material.

LIMITATIONS

There were certain limitations placed on the writer in preparing this study. The records were brief and in most cases contained only the material necessary for the doctor's purposes. As a result it was often difficult to determine just how much service had been given by the case worker and in what areas she had worked toward helping the patient to a better adjustment. Because of the unavoidable absence of more detailed information in the records, it was not possible to evaluate the patients' adjustments in the community. The criterion for a successful adjustment was the patient's ability to function in the community without a return of symptoms. The unsuccessful group consisted of those patients who were returned to the hospital at some time during their year of trial visit. It must be noted, therefore, that among the successful group there are various degrees of adjustment. For the purpose of this paper, however, it is sufficient that they have found enough satisfaction in their placements to avoid a return of symptoms.

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CHAPTER II

PSYCHIATRIC SOCIAL WORK

A Brief History

From the beginning of recorded time the mentally ill have been the objects of whatever superstitious or social attitudes prevailed in the particular era in which they lived.[1] They were hanged, tortured, or run out of the villages as agents of Satan. At best they could expect no more understanding treatment than the common debtor or criminal who was cast into prison and restrained in chains. In the rare instances when the need for treatment was recognized, the remedy was fantastic and ineffectual, being based on some superstitious preparation of herbs believed to be able to cast out the devil.

Slow as the progress was through the centuries in understanding mental illness, some changes in the treatment of the mentally ill are worthy of note. Each century produced its own benevolent, far-sighted men and women who helped to further more humane treatment of the insane. From the practices of confining them in prison or small pens attached to the family house, grew the asylums with their forbidding, high walls and gloomy interiors. As treatment and understanding of the

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Albert Deutch describes these changes further when he writes:

> The most striking development in institutions for the mentally ill during the present century has been the gradual ascendancy of the curative over the custodial ideal, climaxing a process that has been going on for many years. If the last decade of the nineteenth century saw the significant change in nomenclature from "asylum" to "hospital", the twentieth century has witnessed a transformation in fact as well as name.[2]

With the shift in emphasis from custodial care to curative, came the realization that it was the patient, not the disease, that had to be treated and cured, and that to understand the patient it was important to understand the environment in which he developed. To obtain the necessary information about the patient's past, visits had to be made to the family and other groups in the community. At first the

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2 Ibid., p. 440

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doctors made these necessary contacts, but it soon became evident that help was needed from another source. It was then that the institution officials realized the value of utilizing trained social workers to obtain the histories.

Concerning the importance of the history in relation to a better understanding of the patient and his treatment needs Hester Crutcher writes:

> To understand a mental illness one must know the environment (past and present) of the individual and his reactions to it, for these stresses have usually played an important part in the patient's breakdown. The patient's relationships within the family situation, both current and earlier, as well as his social relationships, are especially important. The obtaining of such material is one of the functions of the social worker. A well-taken history will not cure the patient's illness but it may contribute dynamic material indicating what treatment is necessary to relieve the condition.[3]

At the same time that psychiatry was turning to social work for help in the treatment of mental patients social work was itself turning to psychiatry. The social worker had long been interested in the families of mentally ill patients, and particularly in the rehabilitation of the mental patient who was discharged from the hospital. It was not until early in the twentieth century, however, that this work was organized

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in the United States.

In Europe provisions for after care of mental patients began as early as 1841.[4] The work was adopted in England in 1880. The program was carried on by volunteer societies, supported by private funds, working in close association with officials of asylums to provide protection, assistance, and homes for patients discharged from the hospital.

The State Aid Association, in the United States, organized a system of after care committees for the supervision of patients in homes. These committees were assigned to each state hospital. They soon proved their worth in assisting patients who would otherwise have been turned out into the streets or to the Department of Public Charities.

In New York the state took over the after care work previously done by private agencies, and established social service departments in all the state hospitals. In Massachusetts in 1913 Danvers State Hospital and Boston State Hospital added a social worker to the staff. Other hospitals followed. A provision was soon added to the insanity laws requiring a year's period of parole outside the hospital before discharge from the hospital books. This provision made the social work department more official and also gave, "increased opportunity

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4 Most of the following material was adapted from: Ruth A. Geganheimer, After-Care Work with Mental Patients from the Point of View of a Psychiatric Social Worker

for the hospital, through its social worker, to guard against a recurrence of the disease, and for the patient to become socially and economically adjusted".[5]

Social work after care proved its value to both the community and individual patient, not only as an extension of hospital treatment but also as an "approach to the problem of prevention and early recognition and treatment of mental disease".[6]

From this early, well-defined function psychiatric social work has grown to include all social work aimed at helping the mentally disturbed, regardless of the nature or degree of the illness. Margaret Hagan describes this as follows:

> Psychiatric Social Work is social work undertaken in direct and responsible working relations with psychiatry. Practiced in hospitals, clinics, or under other psychiatric auspices, its essential purpose is to serve people with mental or emotional disturbances. A psychiatric social worker is one who has specialized training and experience for such practice.[7]

The psychiatric social worker in a state mental hospital today has many varied duties in addition to her original purpose of providing after care for patients being released on visit from the hospital. Some of these extra duties are;

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5 Ibid., p. 781
6 Ibid., p. 805
7 Margaret Hagan, Social Work Year Book, 1947, pp. 361-362

taking social histories, helping the patient to accept his hospitalization, personal services to the patient, location of relatives, obtaining permits for lumbar punctures, shock therapy, and commitment. There are services to relatives which the social worker regularly undertakes; such as, helping them to accept the patient's hospitalization and explaining hospital rules and procedure. When the patient is ready for trial visit in the community, it is the social worker who makes the preparole investigation, prepares the relatives for the patient's return to the home, or helps place the patient in a suitable job and home, in situations where the family cannot or will not make the necessary plan for him.

Some of these duties are summed up by the Group for the Advancement of Psychiatry as follows:

(a) The interpretation of the hospital's facilities and program to the patient;

(b) Assistance to the family with problems arising from the patient's admission to the hospital, amelioration of family anxieties in relation to the threat of having a mentally ill relative, interpretation to the family of the hospital's treatment procedure;

(c) Formulation of plans, with the assistance of other community social agencies, which might make admission less urgent or occasionally prevent unnecessary or ill-advised admissions.

(d) Establishing a relationship with the family which will enable them to maintain a positive, non-rejecting attitude

> throughout the period of care, and ultimately helping them to receive the returning patient with understanding and acceptance.8

Important and time consuming as these other duties are, the psychiatric social worker in a state hospital finds that the placement and follow-up supervision of a patient on trial visit from the hospital offers the best opportunity for the use of case work skills. The reestablishment of the patient in the community requires a thorough knowledge of the patient's background, deprivations, needs and drives, potentialities, and personal relationships, as well as the intelligent use of community resources, interpretation to relatives, friends, and employers; manipulation of the environment, ironing out difficulties as they arise, being a supportive stabilizing influence on the patient, and giving him as much insight and understanding about his difficulties as is necessary for him to remain happy and well-adjusted in the community.

The selecting of a job and home for the mental patient offers a challenge to the social worker. It requires not only a thorough understanding of the patient, but also an understanding of the attitudes and acceptance on the parts of the employers and foster families (including landlords, housekeepers, roomers, and others with whom the patient will con-

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8 Group for the Advancement of Psychiatry, Function of Psychiatric Social Work in the Mental Hospital, p. 4

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tinually come in contact). The placement must offer many of the satisfactions which the patient has missed during his lifetime, and avoid whenever possible the anxieties and pressures which contributed to his illness. In situations where difficulties arise they should be worked out by the psychiatrist, social worker, patient, and employer (or foster family) as a team. Close cooperation by members of the above team have produced excellent results in actual practice.[9] It can be expected that even in the most carefully planned placements which take into consideration all the factors which might influence the patient's adjustment in the community, there will be some problems arising which could not have been anticipated in advance. In these situations, and in the many less well thought out placements, the social worker in her follow-up work with the patient should be able to make the adjustments required to relieve the strain.

Concerning the purpose of follow-up work with the patient Lois French writes:

> With the return of the patient to his community, the social worker's task is to aid him in meeting again the relationships of home, family, friends, and employers. Contacts with those in touch with the patients, following up the preparole preparations, are made with the aim of insuring the more understanding treatment. Contact with the patient him-

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9 Olive E. Dorman, "Jobs of Mental Patients", Survey Midmonthly, April, 1944.

> self gives him an opportunity to discuss difficulties in his situation and his attitudes toward them.10

In a placement where most of the patient's needs are satisfied by his employment and personal relationships it necessarily follows that there is less need for intensive follow-up care on the part of the social worker. In many of the less satisfactory placements, however, the need for case work is often great. This need cannot be adequately met due, in many cases, to the pressure of routine work which demands the case worker's time. Many patients get along in the community with a minimum of help from social service. Sometimes this minimum of help is enough. In many cases the mental patient fluctuates at a precarious level, and the balance which keeps him functioning in the community is maintained by whatever understanding and supportive help the case worker is able to give in her periodic visits.

These periodic visits have a twofold purpose. On the one hand they help the patient to accept himself as he really is and thus live within his limitations rather than in a world of fantasy. On the other hand they help to bring mental hygiene information to the patient and to the other individuals with whom he comes in contact. In the latter area mental hospital social workers are in a particularly advantageous posi-

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tion for furthering this educational process.

Lois French describes this trend in mental hospitals by hospital social service as follows:

> ...there are state hospitals likewise concerned with treatment of patients but moving forward at the same time with a growing community program that includes supervision after the patient leaves the hospital, establishment of preventive work through statewide clinics, and increasing cooperative relationships with community agencies concerned with mental hygiene education. Social service concerned only with the patients within the hospital is sometimes described in terms of "history taking" and "supervision following parole". Social work connected with a growing state-wide program can no longer be so described.
>
> The trend of state hospital work, slow as it may seem to many who have a clear vision as to what a hospital program might mean in terms of education and prevention, is definitely in the direction of an increasing share in a community program for the prevention of mental disease. 11

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11 Ibid., pp. 122-123

CHAPTER III

PRESENTATION OF DESCRIPTIVE DATA

In this chapter it is the writer's intention to present an over-all picture of the twenty cases studied, including social factors, medical diagnoses, and the intensity and nature of social service activity.

All of the patients selected for this study were of the white race. All were native born but one, and he was a naturalized citizen. Sixteen of the twenty were considered as belonging to the marginal income group at the time of admission to the hospital, four were dependent, and none were comfortably well off.

There were eight men and twelve women in the group. Their ages ranged from twenty-one to seventy-five with a median age of forty-five. Most of the ages were concentrated in the thirties and fifties.

Of the twenty patients studied twelve were single, three married, two widowed, two divorced, and one separated. Of the two divorced, one was married and divorced three times.

These facts may be made clearer by the following tables.

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TABLE I

RACE, SEX, AND AGE OF THE TWENTY PATIENTS STUDIED

		Number of Patients
Race	White	20
	Other	0
Sex	Male	8
	Female	12
Age	Range of ages	21-75
	Median age	45

TABLE II

MARITAL STATUS OF THE TWENTY PATIENTS STUDIED

Marital Status	Number of Patients
Single	12
Married	3
Widowed	2
Divorced	2
Separated	1
Total	20

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Table II shows that twelve patients, or more than half of the patients studied were single. Of the eight who have been married, five were unattached at the time the study was made. These figures are not surprising in a study of this kind as it is to be expected that patients referred to social service for community placements would not have marital responsibilities or strong domestic ties.

TABLE III

MEDICAL DIAGNOSES OF THE TWENTY PATIENTS STUDIED

Medical Diagnoses		Number of Patients
Dementia Praecox		9
With Mental Deficiency	1	
Paranoid Type	5	
Hebephrenic Type	1	
Catatonic Type	2	
Manic Depressive Psychosis		3
Depressed Type	1	
Manic Type	2	
Mixed Type	0	
Psychosis with Convulsive Disorders		1
Psychosis with Mental Deficiency		1
Psychosis with Cerebral Arteriosclerosis		2
Psychopathic Personality		1
Alcoholic Psychosis		2
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Table III shows the medical diagnoses of the twenty patients studied. Nine, or almost half of the group, were diagnosed as Dementia Praecox. According to H. Warren Dunham, Dementia Praecox constitutes between 25 and 40 per cent of the first admissions to hospitals for mental disorders.[1] The proportion found in this sample was slightly higher, constituting 45 per cent of the whole.

The next largest group was Manic Depressive Psychosis which represented 15 per cent of the total. Alcoholic Psychosis and Psychosis with Cerebral Arteriosclerosis each were represented twice and composed together 20 per cent of the total.

In Tables IV through X the patients studied have been divided into two groups of ten each. One group includes the patients who made satisfactory adjustments while on trial visit in the community. The second group includes those patients whose adjustments were unsatisfactory, necessitating their return to the hospital during their year of trial visit. The two groups were compared for such factors as intelligence, education, and personal problems presented at the time of their admission to the hospital, in an effort to determine if these or similar factors were significant in influencing the patient's

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later adjustment in the community.

It is to be noted here that the sample studied is too small to enable any large generalities to be drawn. The results of the comparative study are interesting and significant however, in drawing conclusions regarding the twenty patients who were included in the sample.

TABLE IV

INTELLIGENCE OF THE TWENTY PATIENTS STUDIED

Intelligence	Number of Patients whose Adjustments were Satisfactory	Unsatisfactory
Inferior	5	1
Borderline	2	0
Average	2	7
Superior	1	2
Total	10	10

TABLE V

EDUCATION OF THE TWENTY PATIENTS STUDIED

Schools Attended	By Patients whose Adjustments were Satisfactory	Unsatisfactory
None	1	0
Grammar school	6	5
High school	2	3
College or business school	1	1
Graduate or professional training	0	1
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Table IV gives a picture of the intelligence of the patients studied. Table V shows the educational accomplishments of the group. A study of these two tables reveals that the amount of education achieved by the patients is commensurate with their intelligence.

It is interesting to note also that of the group making satisfactory adjustments, seven were of inferior or borderline intelligence, while in the unsatisfactory adjustments group, nine, or almost all, were average or superior in intelligence.

These tables show a tendency toward better adjustments in the inferior and borderline groups, as in general, the problems presented by these groups are problems in re-education and retraining for community living. These are relatively modifiable factors and ones with which the social worker is particularly equipped to work.

Table VI shows the extent to which mental illness was found in the families of the patients studied.

TABLE VI

MENTAL ILLNESS IN FAMILIES OF PATIENTS STUDIED AS SHOWN BY HISTORY AT TIME OF ADMISSION

Member	Number of Patients whose Adjustments were Satisfactory	Unsatisfactory
None	4	5
Mother	5	0
Father	0	0
Siblings	1	2
Others **	0	1
Unknown	1	2
Total*	11	10

** Aunt and grandmother
* One case had both mother and sibling

The one significant fact pointed out by Table VI is the mental illness of the mothers of five, or half, of the group which made satisfactory adjustments.

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Table VII shows the reasons why patients were referred to social service for placement instead of to their own family.

TABLE VII

REASONS WHY FAMILY DID NOT MAKE PROVISIONS FOR PATIENT AT TIME OF RELEASE ON TRIAL VISIT

Reason	Number of Patients whose Adjustments were Satisfactory	Unsatisfactory
No family	2	1
Family not interested	1	4
Family not able to take responsibility	4	4
Family not suitable or desirable	3	1
Other reasons	0	0
Total	10	10

Table VII shows that the family's attitudes regarding placement plans for the patient have no appreciable effect upon the adjustments of the group as a whole.

Table VII shows the reasons why patients were referred to social service for placement instead of to their own family.

TABLE VII

REASONS WHY FAMILY DID NOT MAKE PROVISIONS FOR PATIENT AT TIME OF RELEASE ON TRIAL VISIT

Reason	Number of Patients whose Adjustments were Satisfactory	Unsatisfactory
No family	2	1
Family not interested	1	4
Family not able to take responsibility	4	4
Family not suitable or desirable	3	1
Other reasons	0	0
Total	10	10

Table VII shows that the family's attitudes regarding placement plans for the patient have no appreciable effect upon the adjustments of the group as a whole.

The psychiatric social worker has a definite responsibility to the patient on trial visit in the community during the year of supervision. She can be of real help by offering concrete or personal services, or merely through her personal contact and influence on the patient. Lois French sums up the function of the psychiatric social worker supervising the patient in the community as follows:

> The chief purpose of social service supervision is to remove environmental difficulties in the path of the patient's recovery or to help him cope with them. The social workers do not necessarily feel themselves responsible for improving the patient's mental health; it is their function to promote some sort of adjustment on the part of patients who, even if still psychotic, are considered by the doctors able to live in the community and also to help patients to accept rehospitalization with a minimum of fear and difficulty if this should become necessary.[2]

The social worker is responsible for making a social diagnosis and selecting for intensive treatment those patients who can make the best use of the skills the worker has to offer.

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2 Lois French, Psychiatric Social Work, p. 233.

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Table VIII gives a picture of the frequency of visits to patients made by the social workers.

TABLE VIII

FREQUENCY OF SUPERVISION VISITS TO PATIENTS ON TRIAL VISIT BY MEMBERS OF THE SOCIAL SERVICE DEPT.

Frequency	To Patients whose Adjustments were Satisfactory	Unsatisfactory
Weekly	2	1
Semi-monthly	6	2
Monthly	1	2
No regular visits	1	5
Total	10	10

Table VIII shows that the group which made satisfactory adjustments in the community received considerably more frequent visits from social service than did the group whose adjustments were unsatisfactory. In the satisfactory group eight, or 80 per cent, received weekly or semi-monthly visits, whereas in the unsatisfactory group seven, or 70 per cent, were visited only monthly or received no regular visits.

The sample used in this study is too small to permit any general conclusions to be drawn from Table VIII, but

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The sample used in this study is too small to permit any general conclusions to be drawn from Table VIII, but

it seems safe to conclude from the table that in the twenty cases studied the frequency of follow-up supervision visits by the social worker was a factor in the success or failure of the patients' adjustment.

TABLE IX

PERSONAL PROBLEMS OF PATIENTS STUDIED AS SHOWN BY HISTORY AT TIME OF ADMISSION TO HOSPITAL

Problem	Number of Patients whose Adjustments were Satisfactory	Unsatisfactory
Family relationships	6	5
Marital difficulties	2	3
Financial insecurity	2	5
Medical problems	3	5
Employment difficulties	4	3
Emotional dependency	3	5
Social maladjustments	8	3
Insecurity and inadequacy feelings	7	9
Illigitamacy	1	2
Alcoholism	2	3
Mental inadequacies	7	1
Promiscuity	4	1
Institutionalized	3	0
Unstable personality	4	6
Homosexuality	1	2
Other problems	0	1
Total	57	54

TABLE IX

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Table IX shows the kinds of problems which the patients faced at the time of their admission to the hospital. It also shows the number of times each of these problems appeared in the twenty cases studied. It must be noted, however, that these problems were not weighted in order of their importance in the mental breakdown of the particular patient. Each problem was given one mark for every time it appeared, and no distinction was made between a problem which was a precipitating factor and one which was a minor factor. This was done to draw a comparison between the total problems presented by the group which later made a satisfactory adjustment in the community, and the problems faced by the group whose later adjustment in the community proved unsatisfactory. It is interesting to note the marked similarity in the totals of both groups. These results show an average of 5.7 problems per patient in the satisfactory group, and an average of 5.4 in the unsatisfactory group. It seems reasonable to assume, therefore, that the number of problems which together precipitated a patient's mental breakdown will not be an important factor in determining his later adjustment. This does not mean, however, that the nature and magnitude of the problems can be discounted.

TABLE X

SERVICES MADE AVAILABLE TO PATIENTS ON TRIAL VISIT FROM THE HOSPITAL BY THE SOCIAL WORKER SUPERVISING THEM

Services	To Patients whose Adjustments were Satisfactory	Unsatisfactory
Supportive help	4	1
Interpretation to relatives	2	2
Interpretation to employers	6	4
Social adjustments	5	3
Referral to other resources	6	3
School or training	3	0
Recreation made available	3	1
Counseling services	6	2
Employment	9	9
Living arrangements	9	7
Personal services	2	1
Other services offered	1	0
Total	56	33

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Living arrangements	9	7
Personal services	2	1
Other services offered	1	0
Total	56	33

Table X shows the kinds of services given by social service to patients on trial visit and the number of times each service was offered. In this table as in Table IX the services are not weighted in order of their importance, but merely point out how the total number of services given to the two groups compares. It is interesting to note that the average number of services given to each patient in the successful group was 5.6, or very near the average number of problems presented by the group. In the unsuccessful adjustment group the average number of services offered was only 3.3 per patient. It follows then that in the latter group, the services offered by the social worker met little more than half of the problems presented. It might be interesting to see if the same results were found in a study representing a much larger number of cases. For the present study, however, these findings seem significant.

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CHAPTER IV

PRESENTATION OF EIGHT CASES

The twenty cases studied can be classified generally into six groups, according to the fundamental need or problem which must be met by the placement situation in order for the patient to make a satisfactory adjustment.

The following eight case presentations are representative of the six groups and are as nearly proportionate to the number of cases in each group as was possible.

Group I represents the patients who were mentally deficient and rejected from an early age. Their problem is one of reeducation for community living. The patients in Group II are dependent personalities who face the problem of planning a new life for themselves without the help of their marital partners. Group III shows the over-protected patient of superior intelligence who wants to be independent but has not reached the maturity for facing life's situations. In Group IV the patients are unable to care for themselves due to old age or infirmity. Their problems arise from their inability to get along with the person upon whom they are financially dependent. Group V represents only one patient who is well adjusted and stable. Her problem is financial support and a place to live. Group VI also represents one case, that of the

CHAPTER IV

PRESENTATION OF EIGHT CASES

conflict in the mind of a mother who must reveal to her adolescent daughter the fact that she is an illegitimate child.

Case A.

This is the case of Edith B., a twenty-nine year old, single woman of borderline intelligence, who was admitted to the hospital because of threats of violence against her sister, hallucinations, and generally perverse and stubborn behavior. She was diagnosed as Dementia Praecox with mental deficiency, and was a difficult patient consistently during her hospital stay.

Edith was the fourth of five children born into an Italian-American home of marginal income. When Edith was five years old, her mother was committed to a state mental hospital where she remained until her death. The children were all placed in foster homes by the Division of Child Guardianship. Edith soon began to show signs of becoming a behavior problem and was tried in various foster homes always with the same unsatisfactory results. She was a poor student, had a moody and seclusive nature, and disagreeable disposition. At the age of thirteen, Edith was assaulted and raped. She was later sent to the Walter E. Fernald School for special training. She remained there for ten years, completing grammar school. Edith was discharged from the Fernald School at twenty-three years of age and went to live with her sister who was married and with whom Edith had had little contact since early childhood. Edith obtained a job in a liquor bottling plant where she proved a good, dependable worker until she began to drink excessively. She began also to have sexual experiences with men and kept late hours. This precipitated conflict in the home and Edith left and found a room with a girl friend. She admitted having homosexual experiences with her roommate. Edith remained asocial and difficult to get along with, and when definite paranoid symptoms appeared, she was hospitalized at family's request.

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Edith's fundamental problem was the loss of her mother (at age five) and the rejection by her father shortly after (by giving up the children to the Division of Child Guardianship). Edith felt unwanted and unloved and showed her resentment by asocial disagreeable behavior. Her failure in school and repeated attempts at foster home placements intensified her insecurity and inadequacy feelings. Because of her mental limitations she was unable to cope with her problems. The sexual assault when Edith was thirteen precipitated masturbation and later promiscuity. Because of the length of time spent in an institution, Edith lost contact with the outside world, and the social maladjustments and failure to fit into a family group upon her discharge resulted.

Edith was referred to social service by the staff psychiatrists for employment and living arrangements as her family was unable to make the necessary plans for her.

A position as a domestic for a middle-aged couple was secured for Edith. The house was an attractive cottage in a Cape Cod town. Edith had a pleasant room of her own with private bath. The man of the house was good-natured and accepting; the woman intelligent, interested, and fond of Edith. She hired a graduate of Fanny Farmer's Cooking School to teach Edith cooking.

Through the social worker's interpretation of Edith's background and deprivations, the employer achieved a good understanding of Edith as a person and her interest in the girl led her to arrange a supervised recreation program of movies, swimming, shopping trips, and church activities such as Edith had never before experienced. She introduced the girl to young domestics from the other homes in the town and encouraged these friendships. She helped to reeducate Edith for living in the community. She was kind, and at the same time knew how to be firm when Edith exhibited a sullen mood. Edith was shown how to open a back account and was encouraged to save weekly sums. The social worker visited Edith twice a month and these interviews were used for talking over any difficulties which had arisen

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since the previous visit.

> Edith accompanied her employers to Maine on their vacation. When they returned home again, Edith showed the social worker a picture of the cottage in Maine and referred to it, happily, as "our cottage". Edith had at last achieved a feeling of "belonging". She made a satisfactory adjustment in the home and now felt that she was wanted and her services, no matter how simple, were satisfactory and essential.

> Edith was able to identify with a good mother figure (in her employer) who could be both kind and firm. She was no longer threatened by a job she could not perform well and consequently her inadequacy feelings and fear of failure were no longer problems.

The basic factor influencing this patient's good adjustment in the community was an intellegent, interested employer who was able to supply substitute family relationships which offered all the satisfaction and security heretofore missing in the patient's life. Other factors included: improved social relationships (making friends with domestics from other homes); good recreation made available (swimming, movies, shopping trips, and Church activities); occupational training provided (cooking lessons); and the establishment of goals toward which the patient could work (savings account and merit raises). These latter factors were important in contributing to the patient's total adjustment and reeducation for community living. The first factor was basic, however, in that it met the patient's emotional need for love, and security.

The part played by the social worker in the supervision of this patient was an important factor in influencing her satisfactory adjustment. During the trial visit period she remained interested and active, ready to talk over and work out problems as they arose.

Case B.

> This is the case of Christopher M., a thirty year old, epileptic, single man who was transferred to Boston State Hospital from a state school for the feeble-minded because of a psychotic episode in which he became depressed and agitated at intervals. His depression was due to his long confinement in a state school (twenty-three years). He said he wanted to be among normal people and considered himself the only normal patient at the state school. When transferred to the Boston State Hospital he was satisfied, feeling he was now among normal people like himself. He was hallucinated and had grandiose ideas about opportunities awaiting him to manage a large radio station. On the wards he was demanding and acted as though he expected his every command to be obeyed. His diagnosis was Psychosis with Convulsive Disorders, Epileptic deterioration.
>
> Chris's history reveals that he and a brother were the sons of their mother's second marriage. There was a daughter by the first marriage, who is an inmate of a state school for the feeble-minded. Both parents were of low intelligence. The father rarely earned more than twelve dollars a week, and the family consequently was supported chiefly by community agencies. As a boy Chris was difficult to manage. On one occasion he tried to set the house on fire. He had a disagreeable disposition, was untruthful, and unpopular with the other boys in school. He was sent to a state school at the age of seven.

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Both of his parents died during his early adolescence. After twenty-three years in an institution he became psychotic and required treatment in a mental hospital.

Chris was referred to social service for placement as he had no family and needed help in becoming accustomed to living in the community after years of hospitalization. He had completed three grades of school and had received some training as a kitchen helper. Chris's problems were mental deficiency, epileptic seizures, (controlled to some extent by medication) and social maladjustments. Chris had been deprived of normal family relationships as a child, having an ambitionless father, insane mother, and only the uncertain financial security provided by community social agencies. In addition to his unhappy home life Chris was mentally deficient and suffered from epileptic seizures. All of these factors entered into making him an asocial inferior feeling person who tried to compensate for his feelings of inferiority by his pompous manner and grandiose ideas. Chris presented a real placement problem, however, as he was capable of doing only menial tasks, but clung tenaciously to the belief that his services were in demand as a radio technician. He was finally persuaded to take a job as a dish washer in a private hospital and encouraged to study radio in his free time. He showed remarkable initiative in getting books about radio and building his own sets, after working hours. Chris needed constant supervision because of his epileptic seizures. The dietician at the hospital took an interest in him and saw that he got his medicine. He shared a room with a young man who was also epileptic. The young man helped socialize Chris by taking him to movies and introducing him to other friends. Chris adjusted well in his job, but the process of reeducating him for community life was a long, hard one. He remained somewhat withdrawn and difficult to get along with. Periodically he would threaten to give up his job and go into radio broadcasting. At these times the social worker would point out the advantages of his job and try to keep him within the security of the hospital.

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He visited Chris twice a month and helped with the reeducation process in collaboration with the roommate and dietician.

The factor most important in influencing this patient's adjustment in the community was the protected environment in which he lived and worked. The dietician and patient's roommate were factors within the environment who with the help of the case worker, provided the patient with supervised recreation (movies and radio work) and social activities (introducing him to other young people) and also supplied the help he needed in controlling his convulsive seizures. The establishment of goals (saving account and radio work) toward which the patient could work was a third factor important in that it provided satisfaction which he did not find in his job.

The social worker played an important part in the adjustment of this patient. His visits were a stabilizing influence on this restless, impractical patient, who needed considerable guidance lest he pursue his unrealistic plan and lose the security of his protected environment.

Case C.

This is the case of Terry W., a twenty-six year old single man of borderline intelligence who was admitted to the Boston State Hospital because of paranoid ideas that people were talking about him which led him to start fights with his fellow employees. He was diagnosed as Dementia Praecox Paranoid Type. During his hospital stay he was hallucinated and withdrawn.

Terry was the second of three boys. His father was alcoholic and luetic. He was not a steady worker and the family was supported by Public Welfare most of Terry's early life. Terry's mother died of cancer when he was eleven years old. She had suffered physical abuse by her husband throughout her married life. Two weeks before Terry was born, his mother jumped out of the first story window to escape her husband's beatings.

At the death of his mother Terry went to live with a maternal aunt. She resented having the responsibility of caring for him and his two brothers and repeatedly scolded and criticized them saying how glad she was that their mother had not lived to see how badly they had turned out. Terry always felt that she preferred his brothers to him and upon reaching sixteen (in the sixth grade) he left school and joined the Civilian Conservation Corps. When he returned home after twenty-one months in camps, he appeared frightened, sullen, and hallucinated. He took the responsibility for the family's support, however, finding employment on a Works Progress Administration job.

Terry and his brothers were all within draft age, and when war broke out, the three boys volunteered. One brother entered the army, the other the navy. Terry was classified as 4-F. He became more withdrawn and antagonistic after his brothers left for service and seemed to feel that the people where he worked were talking about him behind his back. He became openly aggressive toward them and was discharged from his job. As his feelings of persecution increased, he was admitted to the hospital for observation.

Terry's problems were his feelings of inadequacy and inferiority due to his mental deficiency, his asocial personality, a poor physical condition, and lack of training for any field of work.

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Terry's problems were his feelings of inadequacy and inferiority due to his mental deficiency, his asocial personality, a poor physical condition, and lack of training for any field of work.

Terry was referred to social service for employment and home placement as his aunt did not want to take the responsibility of planning for him lest he become a burden to her. As Terry was young, it was felt that he might benefit from some vocational training. He was therefore referred to the Department of Education for training in dairy work. This was something that Terry was interested in, and it offered living arrangements away from home. It took several months for approval for this plan to be obtained, and during that time it was necessary for Terry to live with his aunt. A temporary job was found for Terry as a kitchen helper. His aunt remained critical and unpleasant, but through the worker's interpretation she obtained a better understanding of Terry and was able to modify her attitude toward him to some extent. Although this arrangement was not the ideal one, Terry was able to remain in the community and work regularly until the vocational plan was approved. His social adjustment did not improve to any extent, but he did go to the movies occasionally with his aunt or brothers.

During his period of trial visit in the community Terry was visited once a week by the social worker. Most of the case work centered around helping the aunt to a better understanding of Terry, and to a realization of what praise and approval meant to him. The interviews with Terry were spent in encouraging him during the waiting period and talking through his problems with him as they arose.

The factor most important in influencing the patient's satisfactory adjustment in the community was his aunt's relatively modifiable attitudes toward him and her ability to use case work help in achieving a better understanding of the patient. Second in importance was the establishment

of a goal (vocational training) to which the patient could look forward.

The excellence of the case work service was a third factor in influencing the patient's adjustment. Both the patient and his aunt were given help in understanding each other, and these two people heretofore antagonistic to each other were able to get along with a minimum of discord.

Case D.

> This is the case of James T., a forty-four year old single man of inferior intelligence who was admitted to the Boston State Hospital because of an alcoholic episode in which he went up and down streets ringing doorbells. During his hospital stay he was pretentious at all times and preoccupied with philosophic and religious questions. He thought he had mystic powers and received messages from the supernatural world. He was kept busy telling fortunes for the other patients. His diagnosis was Dementia Praecox, Hebephrenic Type.
>
> James was the fourth of eight children, born in Finland and brought to the United States at the age of six by his parents. He could speak no English when he started school and dressed so oddly that the other children made fun of him. James was a shy boy and begged to leave school because he felt he was "different". After leaving grade school he did odd jobs around the neighborhood. He remained seclusive, irritable, and stubborn and never made any friends outside his own family. He developed hyperchondriacal ideas about his spine, identifying with his father who was paralyzed with a spinal injury.

James left home at the age of sixteen and was not heard from for seven years. When he returned, he gave no explanation for his absence. He was shabbily dressed, and appeared irresponsible and ambitionless. During the twenty-one years that followed James supported himself by doing odd jobs. In that period he was hospitalized five times in mental hospitals before the psychotic episode which preceded his commitment to Boston State Hospital.

James's problems were his feelings of inferiority and inadequacy for which he overcompensated by trying to appear learned in the discussion of religious and philosophic questions. James had always felt unwanted and unloved and developed a sensitivity which found escape in alcohol.

James had always felt that he was his mother's illegitimate child because he was born in Finland while his father was in the United States. He was convinced he had heard his mother admit that he was the son of a blacksmith. Consequently he felt he was despised by both parents. His inferiority and feelings of being unloved resulted in asocial, seclusive behavior. He understood that it was his sensitiveness to being criticized and unwanted that caused him to drink. He was unable to control his drinking in spite of the insight he showed.

James was referred to social service for work placement and living quarters as his family was not interested in making the necessary plan for him.

James was placed in a rooming house where he did general cleaning. His services were in demand in all the other houses in the neighborhood, and James soon found that he had more jobs than he could possibly fill. His landlady, however, demanded precedence over all others and always paid his fee grudgingly.

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James was placed in a rooming house where he did general cleaning. His services were in demand in all the other houses in the neighborhood, and James soon found that he had more jobs than he could possibly fill. His landlady, however, demanded precedence over all others and always paid his fee grudgingly.

He occupied a small, dark room in the basement of the house which was very damp and depressing. James got along satisfactorily in the community for almost six months. During that time the social worker tried to interest him in joining Alcholics Anonymous but he was always "too busy" to attend the meetings. Efforts were made also to encourage saving as he earned more money than he needed for ordinary living expenses. James never did open a savings account but spent his money as he got it. He worked ten hours a day, and had no recreation or friends.

James formed the habit of sleeping late in the morning. His landlady was annoyed by this and began to complain of his laziness. She felt that his services were not worth what he charged for them and told him he was too slow. James began to feel that she did not like him and became so sensitive that he remained in his room for days at a time. During these periods James would consume large quantities of cognac, never bothering to eat any food. These drinking spells became more and more frequent until it became necessary to return him to the hospital.

During James's stay in the community he was visited by the social worker on the average of once a month. As James was usually working, most of the time was spent talking with the landlady and listening to her complaints about James.

James's placement was considered unsatisfactory as he was returned to the hospital within a year after his release on trial visit. There were several reasons for the failure of this placement. Probably the most important of these factors was the relationship between the patient and his landlady. The landlady had been a temperance lecturer and never full accepted the patient, who was an alcoholic. He felt her rejection of

him which she did not attempt to disguise. Because of his need for acceptance and praise, which was not satisfied, he found his escape in alcohol. Another important factor was lack of spare time activity. Because of the patient's tendency to drink it was essential for him to make friends and find recreation which would prevent his remaining in his room and brooding. The lack of intensive supportive treatment by the social worker and failure to identify with the patient rather than the landlady may be considered another contributing factor in the failure of this placement.

GROUP I

Cases A. through D. are representative of eight cases which have the same fundamental characteristics. The eight patients in this group all suffered from basic feelings of inferiority and insecurity resulting from early parental loss or rejection. They were all of limited intelligence, six being inferior and two borderline. Their mental limitations also contributed to their feelings of inadequacy and fear of failure (for which some of them overcompensated by grandiose ideas and pompous mannerisms). All eight of the patients in this group were asocial in personality. Only three were institutionalized but all showed the same withdrawn, seclusive behavior and general distrust of people, characteristic of patients who have spent most of their lives in a mental institution.

None of the eight had received any vocational training and were unprepared to work in any but the most unskilled jobs. In short they were totally unprepared for living in the community. They were untrained and mentally incapable of making decisions and keeping out of trouble if left on their own. In spite of their negative background, seven of the eight patients in this group made satisfactory adjustments in the community.

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(in six cases) contained one or more interested persons who gave the guidance, praise, and encouragement so necessary to this group of patients. The interested person (usually the employer) also undertook the reeducation of the patient placed in her care, helping with such everyday activities as shopping, budgeting, planning spare time activities, and so forth. Of the eight patients in this group, four were placed as domestics in private nursing homes where the women employers took a personal interest in them. One (Case B.) was placed as a kitchen helper in a private medical hospital where the dietician and another kitchen helper took joint responsibility for him. The sixth of this group was placed in a private home (Case A.) where the employer supervised her. One was placed with his aunt pending apprival of training plans. The aunt was able to give the patient the necessary approval and guidance after she achieved a better understanding of him, (Case C.). Only one patient was sent out on his own to live in a room (Case D.); and missing the protection he needed, he soon had a recurrence of symptoms and was returned to the hospital.

Important as recreation and social relationships are to a well-adjusted personality, the patients in this group seemed to be able to remain in the community with very little of either in many cases. They have lived within themselves for so long that they do not seem to have the same need for companionship as shown by some of the other groups. Consequently

recreation and social activities are of secondary importance in influencing the adjustments of patients in this group.

The role of the social worker during the supervision period was influencial in the seven satisfactory adjustments as she gave the necessary interpretation to the employer from time to time and coordinated all the efforts in the reeducation of the patient. In the one unsuccessful case, the worker did not take on the supportive role in the absence of any interested person. Identification with the landlady (Case D.) instead of with the patient might have contributed also to his failure in adjusting to the community.

Case I.

> This is the case of Lucy B., a forty-one year old married woman of average intelligence, who was admitted to the Boston State Hospital after she called the Society for the Prevention of Cruelty to Children and asked them to come after her two sons before she killed them. During her hospitalization she was excitable, profane, and very disturbed. Her diagnosis was Dementia Praecox-Paranoid Type.
>
> Lucy's parents were English born, of marginal income. Little is known of her early life. She was the youngest of three children. The other siblings were boys who had never been very close to Lucy. When Lucy was married two years her father suddenly left her mother with no reason except that he was tired of living with her. Lucy's own marriage was not a happy one. Her husband was lazy and rarely supported her or the children. Shortly before her hospitalization he was convicted on charges of adultery with a minor and sentenced to a state prison. Lucy was receiv-

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Case I.

ing Aid to Dependent Children at the time of her admission to the hospital. The two boys were placed in a religious institution with a maternal uncle paying their board.

While Lucy was in the hospital, her husband was released from prison. He visited her on a few occasions but was always uncooperative and superior acting. He would disappear for weeks at a time and could not be counted on for looking after Lucy when she was released from the hospital. Lucy had a brother who was interested in her but refused to accept full responsibility as she was so emotionally dependent, that she clung to him and never did anything for herself. He felt she should be encouraged to take some responsibility herself.

Lucy's problems, in addition to a serious marital difficulty, were emotional dependency which she showed toward anyone who took an interest in her, her inadequacies in planning a new life for herself and children without her husband, and a poor physical condition which included diabetes and anemia. Some of her inadequacies came from her feelings of being unattractive. Her husband had often reminded her of how ugly looking she was, and she became shy and sensitive about her appearance. Lucy had also found that people deserted her (particularly men) and thus she clung tenaciously to anyone who was kind to her. She needed approval and found this approval in her children. Her one aim consequently was to return to her sons and make a home for them.

Lucy was referred to social service for help in job placement and in finding living quarters. The doctors had advised againsy Lucy's returning to her husband or attempting to make a home for her two boys until she showed that she could manage for herself for a reasonable length of time. As she had previously been employed as a clerk in a Woolworth store and expressed the desire to return to that kind of work, a job of this nature was obtained for

her. It was only a part time job, however, and paid a very small salary.

A room was found for Lucy in a private home. The family renting the room had never had any roomers before and seemed to resent a stranger in the house. They accepted Lucy, however, because they needed the financial help brought in by the rent. The man of the house was in ill health and had a disagreeable disposition. The woman was more understanding but was inquisitive and talkative. They were not informed of Lucy's recent hospitalization in the beginning and when they later demanded an explanation, were shocked and disgraced to have had a mental patient in their house. Because of Lucy's serious financial problem, due to her part time work, she was unable to provide herself with any recreation and was obliged to remain in the room every evening. Her hopes of taking her boys out of the home where they were placed were constantly being crushed by the doctors' refusing to permit her to reestablish her own home. Lucy, after repeated attempts to show her worthiness, removed the children from the institution without permission and became so disturbed when they were forcibly taken from her, that she was returned to the hospital in a highly excited state. While Lucy remained in the community she was visited on the average of once a week by the social worker. Some effort was made to refer her to a family agency for supplementation of her earnings. As she resisted this referral, nothing further was done toward alleviating her need.

There are several factors which prevented this patient from making a satisfactory adjustment in the community. Most important was the lack of substitute satisfactions to replace those she had given up (home and children). This patient was a dependent personality, and needed the love and approval given her by her sons. As this need

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could not be directly met by permitting her to have the children with her, she needed some assurance that she could have them at some definite time in the future. The establishment of such a goal was important.

A second factor was the unpleasant living arrangements. Patient was a shy and sensitive person and felt the critical, distrustful attitude of her landlords toward her.

A third factor was the patient's extreme financial difficulty. She earned only enough for room and board with nothing left over for other necessities. As a result she could afford none of the recreation she so badly needed. She got some satisfaction from her job, but it was her leisure hours which became a problem as she had time to think and brood.

The case work services offered in this case were not important as a factor in influencing this unsatisfactory adjustment.

Case J.

> This is the case of Mary S., a forty-seven year old married woman of average intelligence who was admitted to the Boston State Hospital as she was causing a disturbance in the housing project where she lived. She refused to pay the rent, and was ordered to vacate. She would not give up the apartment, however, and became violent when the police were called to evict her. While in the hospital she was quiet and cooperative. Her diagnosis was Manic Depressive Psychosis, Manic Type.

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Case 1.

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Mary was the older of two girls and, as far as is known, had a normal childhood and early development. When she reached the age of sixteen and her third year of high school, her mother became mentally ill and was hospitalized in a state mental hospital. Mary had to leave school and keep house for her father and sister. Her mother's illness and this new responsibility had an effect upon Mary, as she soon stopped seeing her friends and became moody and hard to get along with. She held positions as a domestic and got along particularly well in one job as a companion to a wealthy woman.

Mary was separated from her husband at the time of her admission to the hospital. He was paying through the court for support of her and their four children. The trouble between Mary and her husband grew out of his dependency upon his family. She resented his discussing his plans with his mother instead of with her, his wife. She began to suspect that he was also giving a large part of his salary to his mother, and many quarrels ensued. When Mary became angry, she threw pots and pans at him. After her hospitalization her husband took the four children to his mother's home, where they were still living at the time of Mary's release on trial visit from the hospital.

While in the hospital Mary worked in the laundry. She learned how to operate some of the machines and seemed very happy in her work.

Mary's problems were a poor marital relationship, emotional dependency, and a chronic medical disability. Her marriage was not built on mutual confidence and respect, and living with her husband only increased her feelings of persecution. At the same time she was emotionally dependent and developed psychotic symptoms when he moved out of the house. She had little confidence in herself, and was afraid that she would not make good in a job in the community.

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doctors advised against her attempting to re-establish a home for herself and children. Mary had expressed the desire to work in a laundry as she had learned something about laundry work in the hospital and felt it was the one thing she could do well. She also had gotten along well in the hospital and thought she would like to live in an institutional setting.

A job was found for Mary which offered board and room. It was work in the laundry of a private medical hospital. She operated a hand presser similar to the one she had learned to use at the Boston State Hospital. She liked the work and was happy in her job. The hospital provided board and room and offered the institutional setting Mary had requested. She made some friends in her work and found recreation in movies and church work. Mary did not seem to be troubled by not having her children with her. She visited them occasionally, but made no mention of taking them back at the present time. She rarely mentioned her husband and seemed to think of him as someone in the past. Mary made a good adjustment in her placement and was happier than she had been for many years.

During Mary's trial visit in the community, she was visited by the social worker on an average of twice a month. The social worker's role was that of an interested, friendly person who talked over with Mary any problems which might be bothering her and helped her to clarify her thinking regarding her children and marriage.

The most important factor in the adjustment of this patient was the satisfaction which she found in her job. She had felt that she could never get along on her own in the community and was enthusiastic about the success of her endeavor. It gave her a feeling of independence and self assurance she had never previously known. Recreation was

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important to this patient also, as she needed some sparetime activity which would prevent her having time to think and build up guilt feelings for 'deserting' her children and thinking only of herself. A third factor of importance was the patient's ability to accept the authority of the doctors' recommendation that she postpone reestablishing her home for the present.

The part played by the social worker during the supervision period was of no apparent significance in influencing the satisfactory adjustment of this patient.

GROUP II

Cases I. and J. represent five cases which have been grouped together because of the similarity of their fundamental problems. The chief problem found in the cases in this group was marital discord. It was a problem of such magnitude that it was considered the precipitating cause of the patients' admission to a mental hospital. Furthermore the doctors had advised against these patients returning to their spouses at the time of release on trial visit. All five of the patients in this group were dependent in nature and faced the problem of making a new life for themselves without the support of even a very poor marital partner. All but one repeatedly expressed the desire to return to their wives or husbands. All the patients in this group had experienced serious financial difficulty during their married life. In the three men this caused fear of not being able to support themselves in the community. The two women (Cases I. and J.) were untrained for any kind of work and experienced the same fears of inability to manage financially. All five were considered to be of unstable personality. They were all of average intelligence. Of the five cases in this group, only one made a satisfactory adjustment in the community.

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In four cases in this group the chief factor in their failure to adjust was the lack of either social or occupational satisfaction which could replace the satisfaction

of their marriage. The three men had been placed in menial, unskilled jobs which were beneath their capabilities as one had been a pharmacist, one a skilled mason, and the third had been in business for himself. They had no social or recreational outlets. The woman (Case I.) whose placement was unsuccessful suffered the same emotional deprivation and lack of satisfying relationships. The one successful case (Case J.) found considerable satisfaction in her work and in the friends she made there.

The two factors of greatest importance in influencing the adjustments of patients in this group are satisfaction found in their jobs, and companionship. Both seem to be of importance, as the patients in this group lack self-confidence in employment and need the satisfying feeling that they are doing a good job wherever they are working. They were all married several years and had grown to rely on the companionship of their marital partner. Deprived of this other person they were helpless to go on. The three men returned to their wives against doctors' orders and suffered a return of symptoms. Case I. sought satisfaction in her children, and when this was denied, her symptoms returned. Case J. found the necessary satisfaction in her job and friends and has been able to remain in the community.

The role of the social worker in these five cases

was relatively unimportant in influencing their adjustment. Something more might have been accomplished in the areas of recreation and social adjustment, but the basic problems required a long term therapy which a social worker in a mental hospital is not expected to provide.

Case N.

> This is the case of Andrew W. a fifty year old, single man of superior intelligence, who came to the Boston State Hospital voluntarily, seeking help with his anxieties aroused during six months of psychoanalysis. His diagnosis was Dementia Praecox Paranoid Type.
>
> Andrew was the younger son of a fire chief, his older brother having died at the age of five. Following his brother's death, his mother smothered him with attention, and Andrew became so over-protected and sissified that the other children made fun of him. As a child he masturbated excessively. He recalled how severely his mother scolded him when she discovered this activity. At the age of eight Andrew went to camp for the summer. He was miserable because he could not swim and was not athletic. He made friends with one boy his own age, however, and together they indulged in mutual masturbation.
>
> Andrew soon showed signs of superior intelligence, and upon completing high school, attended a first class college and law school. He later served with the United States Army in Europe. During his service period he had numerous experiences with French prostitutes and on one occasion ran around the streets kissing all the young men he saw. When Andrew was discharged from service, he went to Constantinople where he tutored a ten year old boy. He returned home suddenly because he felt his mother needed him. He became an instructor at a technical institute where he had a good record, until he began to fear

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that people knew about his homosexual tendencies and spied on him. He developed persecutory ideas and gave up his job to seek psychiatric help. During the psychoanalysis Andrew expressed hostility toward his mother who, he felt, had dominated him and his father. He showed excessive guilt about his masturbation and homosexual experiences. He had grandiose ideas and expressed his feeling that only the inferior should work. He decided that he should give the orders and let others do the work. His ambition was to learn to fly in order that he might join the air force and make good will tours.

Andrew's problems were his total unpreparedness for facing real life situations; his social maladjustments which included homosexuality, promiscuity, and the inability to form normal friendly relationships, and his insecurity and inadequacy feelings for which he overcompensated.

Andrew was referred to social service for job placement and living arrangements, as his family was not able to take the responsibility for planning for him. His father had died, and his mother was senile and making her home with a distant relative. Andrew had ten thousand dollars in his own name. No guardian was appointed to supervise the handling of these funds.

Andrew was interested in getting work at an airport. As several attempts to place him there failed, he finally agreed to accept a job as a filing clerk. He took this job only as a means of getting out of the hospital. Living quarters were found for him at a men's club. The rent was more than he could pay out of his wages, but he drew each week on his bank balance to make up the difference. Andrew found his job dull and depressing. He felt it did not make use of his capabilities and gave him too much time to think and fret about his past life. As he was financially independent, he did not have to endure an unpleasant job, so he

resigned and lived on his money. He took flying lessons and chartered a plane to fly to Washington. Within a few months nothing remained of the ten thousand dollars and Andrew was returned to the hospital as his symptoms had reappeared.

While Andrew was on trial visit in the community, he was visited by social service at irregular intervals. These visits were merely of a routine nature.

The factors most important in influencing this patient's failure to adjust in the community were: the absence of an interested person who could give him the supportive help he needed in facing life in the community, the lack of satisfaction in his job, and the large amount of money available to him which destroyed any initiative he might have had for sticking to his job.

The follow-up services given by the social worker were an important factor in influencing this unsatisfactory adjustment because it failed to give the supportive help necessary to this patient.

GROUP III

Case N. represents three cases which have been grouped together because of similar characteristics and the same fundamental problem. The three cases in this group are characterized by immaturity and unstable personalities. They all had dominating, over-protective mothers and weak insignificant fathers. All three developed homosexual tendencies, as might be expected. The patients in this group were all of superior intelligence, but were maladjusted individuals who were unable to solve their own problems or stand on their own feet.

In each case the patient suffered a mental collapse when he or she tried to break loose from mother's domination. They all resented being so dependent upon their mothers, but did not have the necessary maturity to face the resulting guilt feelings, when they openly expressed their hostility.

In two of these cases the patients were returned to the hospital. One made a satisfactory adjustment in the community. All three were placed in jobs beneath their intellectual abilities, two felt that these jobs gave them too much time to think of the past.

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stand on her own feet and live away from home and her mother's domination. The lack of such a relationship in the other two cases resulted in unsatisfactory adjustments. In Case N., finding no escape from his guilt, the patient extravagently spent a small fortune trying to 'flee the world'. The third case could not endure her guilt or the responsibilities which accompanied her emancipation and soon returned to the comfort of her mother's protection. In the two unsuccessful cases the patients received no satisfaction from their jobs. This was not surprising in view of the fact that one took the job only as a means of getting out of the hospital (Case N.), while the other consented to take a job only because the doctors strongly urged it.

The patients in this group seem to need first of all supportive treatment in working out their plans and 'sticking by' their decisions, because they are immature and like children in facing the responsibilities of life. They need the satisfaction of a job well done also, because in spite of their superior intellect, they have severe feelings of inferiority.

The role of the case worker was important in influencing the satisfactory adjustment of one patient in this group. The failure to recognize the need for such supportive treatment in the other two cases in this group might be considered a factor in their unsatisfactory adjustment.

Case Q.

This is the case of Elsie T., a seventy-one year old single woman of average intelligence who was employed as a nurse for an elderly man until her admission to the Boston State Hospital. At the time of admission to the hospital, she was hearing voices and believed that people were breaking into her employer's home to steal his valuables. Her diagnosis was Psychosis with Cerebral Arteriosclerosis.

Elsie was the third of nine children of English born parents. Of the nine only three girls are living. One is married. Elsie and her sister, Mary, are both single and both trained nurses. Mary had previously been hospitalized for several years in a state mental hospital. She was zealous in her efforts to remove Elsie from the hospital as she identified with the patient, saying her own hospitalization was unfair and unnecessary. The other sister showed little interest in Elsie beyond occasional visits to the hospital.

When Elsie was well enough for trial visit, she was referred to social service for suitable placement. Because of her age and failing eyesight, the staff psychiatrists recommended that Elsie be placed in a nursing home or private family, with board and room financed by Old Age Assistance. Elsie's sister was unable to find a suitable home for her and agreed to finance the placement found by the social worker until the Old Age Assistance grant was approved.

Elsie's problems were senility, poor health, and failing eyesight which prevented her working and being self-supporting. This necessitated being financially dependent (at least temporarily) upon a sister who dominated her and who had no understanding of the patient's mental illness. In addition, Elsie was shy and lacked self-confidence, to the extent that she was unable to participate in the plan for her placement.

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The social worker, after obtaining patient's sister's approval, placed Elsie in a family group where there were two school-age children. The arrangement was for patient's sister to pay the board and room pending Old Age Assistance. Elsie had adjusted well in this home for three weeks, when her sister appeared suddenly and removed her, giving as her reason the fact that the family was of a different religion than the patient. This was the beginning of a long series of placements by the social worker and withdrawals by Elsie's sister, each time for a new and unrealistic reason. During the ten months' period that Elsie was out of the hospital on visit, she had fourteen placements, one hospitalization for shingles (lasting three months) and was taken to her sister's room to stay on four different occasions. Because of the difficulty in getting Old Age Assistance (due to the frequent change of patient's residence), it was necessary for the worker to continue seeking cooperation from the sister in paying the patient's board. This arrangement, however, gave the sister the right to supervise the placement.

The worker made semimonthly supervision visits to the patient. In all but one instance, however, the time was spent talking with the sister, appeasing and satisfying her. In the one interview exclusively the patient's, Elsie revealed her fear of her sister, her hostility toward her and at the same time her guilt for feeling as she did about "Mary, who has been so good to me."

While in her sister's home awaiting another placement, Elsie's symptoms reappeared and she was returned to the hospital. She seemed to appreciate the security of the hospital and the protection it offered against her sister's domination. Her symptoms correspondingly diminished with her fears.

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The factor most important in influencing this patient's failure to adjust was her fear of her sister upon

whom she was financially dependent. The sister was still mentally ill and was using the patient as a means of filling her need to dominate. This was another factor as the sister's attitude was fixed and could not be modified by case work services.

The supervision provided by the case worker was also an important factor in influencing this unsatisfactory adjustment as it supported the sister in her dominating role toward the patient. A referral to a private community agency for temporary financial assistance would have enabled the patient to remain at one address and thus insured her eligibility for Old Age Assistance.

GROUP IV

Case Q. represents two cases which reveal the same fundamental problem. The two patients who appear in this group had always been self-supporting, and had never betrayed any unstable personality traits until their admission to the hospital. After their hospitalization, however, it became necessary for them to seek support from a relative as they were no longer able to work, due to a serious physical disability.

In both cases the patient was placed in a private home with the relative paying the board. In Case Q. the relative was dominating and unstable and kept moving the patient from one home to another. In the other case the patient was expected to work in the relative's store although the patient was not physically able to do so. Both patients suffered a return of symptoms caused by anxieties. They both suffered some guilt feeling also, as they felt they should be more grateful for what the relative was trying to do for them.

The chief factor influencing these patients' failure to adjust was the lack of understanding on the part of the relative upon whom the patient was dependent. In both cases the patient was eligible for aid from a public resource and such aid would have made the difference between a satisfactory and unsatisfactory adjustment.

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The social worker's role was a factor in the failure of these two placements as she supported the relative's point of view rather than the patient's and also failed to make the necessary financial arrangement for the patients with the public agency.

Groups V and VI have not been represented by cases as there was only one example in each group. Group V. is the case of a senile woman whose adjustment in the community was satisfactory. Her only problem was financial support and the location of a room where she could live. As she had no relatives, social service found the room and obtained Old Age Assistance for her support. Her adjustment was satisfactory as she was a stable individual who has been able to work out for herself a full program of reading, movies, church activities, and visiting friends to take up her time.

Group VI represents only one patient also. Her problem was her inability to tell her daughter that she was an illegitimate child. The patient brooded about how her daughter would feel about her once she knew. She was sent out into the community to a job in a convent. Her associations with the nuns in the convent intensified her guilt feelings about her illegitimate child. The patient worried so much about telling her daughter (which the doctors had strongly advised that she do) that she suffered a return of symptoms. The two factors which influenced her failure to adjust were

the lack of supportive help in handling her problem and her placement in a convent which intensified her feelings of guilt.

In group V the role of the social worker was unimportant in influencing the satisfactory adjustment as the patient had certain strengths which helped her to work out her own solution.

In group VI the social worker's failure to work through the client's problem with her might be considered a factor in this unsatisfactory adjustment.

CHAPTER V

SUMMARY AND CONCLUSIONS

The study was undertaken to determine what factors were most important in influencing the adjustments in the community of twenty patients released from the hospital on trial visit and placed in jobs and homes in the community by social service. The study, furthermore, was designed to find what was done by the social service workers to help the patients achieve this adjustment.

The group of twenty patients studied included twelve women and eight men. All twenty of the patients were white, and all but one were native born Americans. The ages were widely scattered from twenty-one to seventy-five years. The median age was forty-five. There was a variety of diagnoses among the twenty patients. (See Table III). In the comparison of relatively fixed factors, such as intelligence, education, mental illness in the family, and family attitudes toward planning for the patient when he leaves the hospital, Table IV through VII show that these factors were of no significant importance in influencing the satisfactory or unsatisfactory adjustments of the patients studied. The frequency of social service supervision visits to the patients on visit (see Table VIII) is a factor in itself in influencing the adjustments of the twenty patients studied. Those patients who were able to remain in the community without a return of

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psychotic symptoms received considerably more follow up attention from social service than those patients who were returned to the hospital at some time during their year of trial visit in the community.

In determining the factors which contributed to the patient's satisfactory or unsatisfactory adjustments in the community, it was found that these factors were directly related to the problems which the patient faced at the time of his release on trial visit. That is, the major problems of the individual patient determined in what area he was going to require help. The means in each case of meeting or not meeting that major problem was the chief factor influencing the adjustment.

In eight of the twenty cases the patients studied were of inferior or borderline intelligence and displayed feelings of insecurity and inferiority in their relationships with others. All eight of these patients had suffered from early parental loss or rejection and as a result felt unwanted and unloved. They all showed signs of asocial, seclusive behavior. In meeting this problem of a rejected, mentally defective, untrained patient, the factor most important in influencing his adjustment was a protected environment in which there was some person or persons who undertook the training of the patient and gave him the approval and acceptance he needed. Cases A. through D. illustrate this point. Regarding the satisfactory

adjustments of just such a group of patients Stanley P. Davies writes:

> ...they long to be thought respectable. A great many of them come from homes that have been supported by charity and visited by the police. They have been ridiculed and scorned because they have been slow in school work and at play. "The joy and satisfaction they show at having anyone notice and praise them, either upon their appearance and conduct or upon their savings or work is strong evidence that the love of approbation is a great factor in their success." [1]

Five patients of the twenty studied had serious marital problems which required that they build new lives for themselves without the marital partner. All five of these patients were dependent personalities who had found satisfactions in their marriages regardless of the unhappiness that had accompanied them. As pointed out in Cases I. and J., this problem was met by offering substitute satisfactions for those given up by the dissolution of the marriage. Substitute satisfactions were in the form of employment and social relationships (Case J.). In the unsuccessful cases in this group the absence of such satisfactions was the factor most important in influencing the patient's failures to adjust.

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The same point can be supported by cases with other basic problems (Cases N. and Q.) and by the brief descriptions of cases in Group V. and Group VI.

In every case of the twenty studied, there was more than one problem and consequently more than one need to be met. Services made available by the social workers supervising the twenty patients included referral to other resources (particularly for leisure time activities), individual counseling, interpretation to relatives, friends, and employers; supportive case work, school or training opportunities made available, living arrangements, and employment opportunities secured for eighteen of the twenty patients. (See Table X for Services Made Available).

In the writer's opinion, there are three ways in which social service plays an important role in contributing to the success or failure of the patient's adjustment in the community. First, the social worker must thoroughly understand the needs and problems of the patient and the kind of background from which such needs have sprung. Second, she must select a placement which will meet those needs and secure the interest and understanding of some person in the environment. By interpreting the patient's needs and problems, she must gain the interested person's cooperation. Third, she must stand by ready to iron out difficulties in the environ-

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ment as they arise or help the patient to adjust to them. Case A. illustrates the worker's activity in all three areas and the resulting satisfactory adjustment. Case Q. illustrates the unsatisfactory adjustment resulting from the worker's failure to consider all three aspects of the placement situation.

In ten cases studied, the factors which influenced the patients' satisfactory adjustments in the community were: 1) manipulation of the environment by the social worker, 2) training of an interested person who endeavored to supply the patients' emotional needs, and 3) the support which the patients received from direct contact with the social worker in the absence of an interested person within the patients' immediate environment. The absence of the above three factors were important in influencing the unsatisfactory adjustments of the ten patients who were returned to the hospital.

Important as is the follow-up work of the social worker in helping patients to become rehabilitated in the community, the social worker cannot rely solely upon her own efforts. It is necessary to interest responsible men and women in the community in which the patient is placed to take an interest in the welfare of the patient and offer him the genuine attention and acceptance which is so important to a good adjustment.

Approved,

Richard K. Conant

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Dean

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APPENDIX

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Schedule

SEX Male____ Female____

AGE(nearest birthday)

Econ. Status (at admission) Dependent____Marginal____Above____

Marital Status

Single____Married____Widowed____Divorced____Separated____

Intelligence Inferior____Borderline____Average____Superior____

Education None____

Grammar school____

Night school____

High school____

College or business school____

Graduate or professional training____

Employment Unskilled____ Nature of: By S.S:

Skilled____

Business____

Professional____

Medical Diagnosis

Schizophrenia

Manic depressive

Psychopathic Personality

Involutional Psychosis

Mental deficiency

Paranoid Psychosis

Senile Psychosis

Other

Schedule

SEX Male____ Female____

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Date Released on Visit____

Personal Problems (shown by history at time of ad.)

Family relationships____

Marital difficulties____

Financial insecurity____

Medical problems____

Employment difficulties____

Dependency____

Social maladjustments____

Insecurity and inadequacy feelings____

Illegitimacy____

Alcoholism____

Mental inadequacies____

Promiscuity____

Institutionalized____

Unstable personality____

Homosexuality____

Other needs of patient____

Reasons why Social Service was asked to place Pt.

No family____

Family not interested____

Family not able to take responsibility____

Family not suitable or desirable for Pt.____

Other reasons:

Date Released on Visit____

Personal Problems (shown by history at time of ad.)

Family relationships____

Marital difficulties____

Financial insecurity____

Medical problems____

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Dependency____

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Bimonthly____

Monthly____

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Nature of Case Work Help Given:

1. Supportive help
2. Interpretation to relatives
3. Interpretation to employers
4. Social adjustments
5. Referral to other resources
6. School or training
7. Recreation made available
8. Counseling services
9. Employment
10. Home placement
11. Personal services
12. Other

Mental Illness in Family

None____

Mother____

Father____

Siblings____

Others____

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